OAH 80-0900-32379

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Robbinsdale Rehabilitation & Care Center

RECOMMENDED DECISION

Abbreviated Standard Survey Exit Date: February 18, 2015

This matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge LauraSue Schlatter on May 28, 2015. The Office of Administrative Hearings (OAH) record closed at the conclusion of the hearing on May 28, 2015.

Christine Campbell, Division of Compliance Monitoring, appeared on behalf of the Minnesota Department of Health (MDH or Department). Mary Cahill, Planner Principal with the Division of Compliance Monitoring; Michelle Ness, Supervisor; and William Nelson, Investigator; also participated in the conference on behalf of the MDH.

Robert Rodè, Voigt, Rodè & Boxeth, LLC, appeared on behalf of Robbinsdale Rehabilitation & Care Center (Facility). Kathleen Pankratz, Facility Administrator; Merry Yates, Director of Social Work for the Facility; and Regional Officer for Extended Care, Deb Rose, also participated in the conference on behalf of the Facility. Dana Hilgert, former Facility Social Worker, participated by telephone on behalf of the Facility.

Based on the exhibits submitted and the arguments made and for the reasons set out in the Memorandum below, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

The Administrative Law Judge concludes that the "D" level deficiency issued under F-Tag 203 is supported by the evidence and should be **AFFIRMED**.

Dated: June 11, 2015

s/LauraSue Schlatter
LAURASUE SCHLATTER
Administrative Law Judge

Reported: Digitally recorded (no transcript prepared).

NOTICE

In accordance with Minn. Stat. § 144A.10, subd. 16(d)(6), this recommended decision is not binding on the Commissioner of Health. As set forth in Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within ten calendar days of receipt of this recommended decision.

MEMORANDUM

Introduction

On February 2, 2015, the Office of Health Facilities Complaints (OHFC) at the Department received a complaint regarding the discharge of Resident 1 (R1) from the Facility at 2:45 a.m. on January 21, 2015.[1] OHFC initiated an abbreviated standard survey at the Facility to investigate the complaint on the day it was received. William Nelson, the OHFC investigator, visited the Facility on February 2, 2015 and interviewed Merry Yates, the Facility's Director of Social Services; Kathleen Pankratz, the Facility's Administrator; and the Director of Nursing for the Facility.[2] On February 6, 2015, Mr. Nelson interviewed Jacqueline Smith, the registered nurse who was the night supervisor on duty at the Facility when R1 was discharged. [3] In addition, Mr. Nelson reviewed various Facility documents, including R1's chart, the Facility's policies and procedures, information regarding staff, the daily census, and staff schedules for the dates surrounding the January 21, 2015 incident.[4]

Following the investigation, Mr. Nelson determined that R1's discharge was involuntary and that R1 had not received the notice required before an involuntary discharge. Mr. Nelson concluded that the discharge was not voluntary because R1: 1) returned to the facility in the early morning hours of January 21, 2015; 2) asked to be allowed to stay at the Facility; 3) refused to sign the form acknowledging that she was leaving voluntarily against medical advice; and 4) departed from the Facility in a taxi called by Facility staff.[5]

Mr. Nelson determined that the scope and severity level of the violations was a D, meaning that no harm occurred, but that there was a potential for more than minimal harm.[6] The investigator also determined that the incident was isolated, based on his review of two other files concerning residents who were discharged through the voluntary discharge process after they left the Facility.[7] The investigator found no fault with the

[1] Testimony (Test.) of William Nelson.
[2] The name of the Director of Nursing was not part of the record.
[3] Test. of W. Nelson; Department's written Case Summary (Department Summary) at 4 (May 22, 2015); Ex. F-4-F-5.
[4] Test. of W. Nelson.
[5] Test. of W. Nelson.
[6] Test. of W. Nelson; *see* 42 C.F.R. 488.404(b)(1) (2014); Ex. C.
[7] Test. of W. Nelson.

Facility's handling of those cases. Unlike R1, the residents in those cases never returned to the Facility once they left.[8]

After the investigation was complete, on February 18, 2015, the Department issued a Statement of Deficiencies (Form CMS-2567) to the Facility.[9] In this proceeding, the Facility challenges the deficiency identified by F-Tag F-203 relating to R1.[10]

Regulatory Requirements for Facility Discharge and Bed-Hold

The F203 regulation, 42 C.F.R. § 483.12(a)(4) (2014), requires that, before a facility transfers or discharges a resident, the facility must notify the resident and a family member or legal representative of the resident if known, of the transfer or discharge and the reasons for the transfer or discharge, in writing. The reasons must be recorded in the resident's clinical record. The notice must contain specific information described at 42 C.F.R. § 483.12(a)(6) (2014), including the reason for the transfer or discharge, the effective date, the location to which the resident is being transferred or discharged, a statement of the resident's appeal rights, and contact information for the State long term care ombudsman.[11] Unless certain exceptions apply, the notice must be provided at least 30 days before the resident is transferred or discharged.[12]

The federal regulations governing bed-holds state:[13]

> (1) Notice before transfer. Before a nursing facility . . . allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident . . . that specifies –
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> (i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and
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> (ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b) (3) of this section, permitting a resident to return.

Paragraph (b)(3) (2014) requires facilities to have policies to handle situations where the resident's hospitalization or therapeutic leave exceeds the bed-hold period under the State plan.[14]

Minnesota's State plan defines a bed-hold or bed-hold day as "[a]ny day the resident's formerly occupied bed is being held while the resident is on an authorized,

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[8] Test. of W. Nelson.
[9] Ex. F.
[10] Facility's Summary Letter to Administrative Law Judge (Facility Summary) at1 (May 22, 2015).
[11] 42 C.F.R. § 483.12(a)(4), (6).
[12] 42 C.F.R. § 483.12(a)(5) (2014). The exceptions do not apply in this case.
[13] 42 C.F.R. § 482.12(b)(1) (2014).
[14] 42 C.F.R. § 483.12(b)(3).

documented leave of absence from the facility . . . ."[15] A leave day or leave of absence is defined in the State plan as:[16]

> An authorized, documented overnight absence of a resident from the nursing facility of more than 23 hours . . . . An overnight absence of less than 23 hours is not considered a leave day.

Minnesota's state plan also distinguishes between voluntary and involuntary discharges, as follows:[17]

> When a ***resident initiates or decides*** to leave the facility (not for hospital or therapeutic leave), the discharge or transfer is voluntary. Residents may agree to a voluntary discharge/transfer from the facility. There are no appeal rights associated with a voluntary discharge/transfer.

Facility Documents

In support of its position, the Facility points to three documents that R1 agreed to in writing at the time she was admitted to the Facility, and continued to acknowledge and affirm on several occasions during her stay at the Facility.[18] In addition, the Facility relied on its Bed-Hold Policy, which is a notice provided to residents rather than an agreement they sign.[19]

The first document is the Admission Agreement.[20] Specifically, the Facility pointed to paragraph three of Section III, entitled "Resident's Responsibilities," which states:[21]

> The Resident agrees to abide by all rules, regulations, policies and procedures (including but not limited to the policy and procedure regarding a leave of absence) as are from time to time established by the Center and as outlined in but not limited to the Center's Resource Guide as incorporated herein by reference and to comply with applicable federal, state and local law.

The second document is the Leave of Absence (LOA) Agreement, referred to in the Admission Agreement paragraph quoted above. The LOA Agreement requires a resident leaving the Facility for personal errands and/or overnight therapeutic leave to comply with certain conditions, including a) notifying a nurse before leaving; b) asking a

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[15] Ex. E at E-2.
[16] Ex. E at E-2.
[17] Ex. E at E-9 (emphasis in original).
[18] Exs. 2, 4 and 5; Test. of Dana Hilgert. The parties stipulated on the record, at the opening of the IIDR conference, that R1 was cognitive and her own decision-maker at all times relevant to this proceeding. They also stipulated that R1 signed the Admission Agreement (Ex. 2), the Leave of Absence Agreement (LOA) (Ex. 4), and Agreement to Accept Responsibility (Ex. 8). In addition, the parties agreed that, at all relevant times during her stay at the Facility, R1 had her physician's permission to go on LOAs.
[19] Ex. 5.
[20] Ex. 2.
[21] Ex. 2 at 3.

nurse for any medications that will be needed during the resident's absence; c) personally signing the LOA book and the Agreement to Accept Responsibility form before leaving; and d) notifying the Facility if the Resident will be delayed in returning. The Leave of Absence Agreement also contains the following language:[22]

> Your failure to return by midnight on the date of your expected return will constitute a voluntary discharge from the Center against medical advice if bed hold arrangements are not made.

The third document, the Bed-Hold Policy, states that, "under certain circumstances, a bed will be held . . . while the resident is in the hospital or on therapeutic leave."[23] The Bed-Hold Policy does not state how long a resident can be away from the Facility before the Facility will release the resident's bed if no payment or bed hold arrangement has been made.[24]

Finally, the Facility relied on its Agreement to Accept Responsibility (Responsibility Agreement). The introductory paragraph to the Responsibility Agreement states, among other things:[25]

> If the Resident does not return by midnight of the expected return date indicated below, I understand that this shall be considered the Resident's voluntary discharge from the center against medical advice if (1) payment is not being made by a third party payor or (2) if the Resident fails to make arrangements to pay to hold the Resident's bed.

Factual Background

The pertinent facts are not in dispute. R1, a 59-year-old woman, was admitted to the Facility's Transitional Care Unit (TCU) on December 5, 2014 from North Memorial Medical Center.[26] R1 has a number of diagnoses, including osteoarthritis of the knee, chronic pain, neuropathy, chronic obstructive pulmonary disease, obstructive sleep apnea, diabetes mellitus, and alcohol and tobacco abuse.[27] R1 is cognitive and her own decision-maker.[28] At some point during the time R1 was not able to be in her home, she lost her apartment. At some point, R1 learned her apartment was no longer available for her to return home to once she was ready to be discharged back to the community. The county then began to assist R1 with finding new living arrangements.[29]

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[22] Ex. 4.
[23] There is a copy of the Bed-Hold Policy in R1's file indicating it was hand-delivered to her on the same date she signed the LOA Agreement. Ex. 5 at 1.
[24] Ex. 5.
[25] Ex. 8.
[26] Ex. 1 at 1.
[27] Ex. 1 at 3.
[28] Stipulation of parties. Hearing record, introductory remarks (May 28, 2015) (Stipulated facts).
[29] Test. of D. Hilgert.

R1 signed the Facility's Admission Agreement on December 5, 2014.[30] Three days later, R1 signed the Facility's Leave of Absence Agreement and received the Notice of Bed-Hold Policy.[31]

All of the forms and policies were explained to R1 on several occasions by Dana Hilgert, the Facility's Social Worker assigned to work with R1.[32] R1 was warned that if she were to be voluntarily discharged because she failed to return to the facility or to notify the facility of a late return, she would not be able to take her medications with her, and she would lose her county placement services.[33] R1 had a Physician's Order allowing her to go on LOAs during her stay at the Facility.[34]

On December 27, 2014; and January 2, 3, 13, and 15, 2015, R1 signed out of the facility, each time signing the Facility's Responsibility Agreement.[35] On January 15, Ms. Hilgert met with R1 to review the LOA policies. In particular, she was concerned because R1 had been out past midnight without calling in to notify the facility that she would be late.[36] Ms. Hilgert reiterated that if R1 violated the LOA policy again, she would be voluntarily discharged pursuant to the LOA agreement. R1 stated that she understood.[37]

Later on January 15, 2015, R1 signed out of the Facility at 4:10 p.m., stating she expected to return at 11:00 p.m.[38] She did not return that evening, but instead telephoned the Facility at 11:55 p.m. to notify the Facility that she would return the next morning.[39] On January 20, 2015, R1 left the Facility sometime after lunch with her daughter.[40] R1 did not sign out as she had agreed to under the LOA policy, and as she had in the past.[41] During the evening, Facility staff attempted without success to contact R1 and her family, because R1 had not been in touch with the Facility or made any bed-hold arrangements.[42]

When the Facility had not heard from R1 or her family by midnight on January 20, 2015 about R1's intention to return to the Facility or to request a bed hold, the Facility interpreted R1's actions as a voluntary discharge pursuant to the Facility's LOA policy.[43] However, R1 returned to the Facility at 12:45 a.m. on January 21, 2015.[44] There was no evidence presented regarding the circumstances of her return – how she got back to the

[30] Ex. 2; Stipulated facts.
[31] Exs. 4-5; Stipulated facts.
[32] Test. of D. Hilgert.
[33] Test. of Merry Yates.
[34] Ex. 6; Stipulated facts.
[35] Ex. 8; Stipulated facts.
[36] Test. of D. Hilgert.
[37] Test. of D. Hilgert.
[38] Ex. 8.
[39] Ex. 1 at 12.
[40] Test. of Kathleen Pankratz.
[41] Test. of K. Pankratz. Ex. 8.
[42] Test. of K. Pankratz; Department Summary at 4; Facility Summary at 3.
[43] Facility Summary at 3; Test. of M. Yates.
[44] Department Summary at 4.

Facility, why she was late, or what she said, other than Mr. Nelson's statement that R1 asked to stay at the Facility when she returned.[45]

Jacqueline Smith, the registered nurse night supervisor on duty, contacted Ms. Pankratz, the Administrator, when R1 returned to the Facility. Ms. Pankratz instructed Ms. Smith to proceed with the voluntary discharge process consistent with the Facility's LOA policy. Ms. Pankratz reminded Ms. Smith this was also consistent with R1's education about, and agreement to comply with, the policy.[46]

Ms. Smith provided R1 with a Discharge Against Medical Advice form. The time noted on the form is 1:45 a.m.[47] While R1 apparently did not object orally to the discharge, she did refuse to sign the form, which states, in part:[48]

> This is to certify that I am leaving _____ (facility) at my own insistence and against the advice of the facility and my attending physician. I have been informed by them of the risks and potential complications of my leaving at this time. These risks and potential complications include: _____.

R1 was given a copy of the unsigned form to take with her.[49] At the hearing, the Facility claimed that R1 was advised of risks of voluntary discharge such as loss of the medications provided to her during her stay at the Facility, and loss of county assistance in finding appropriate new housing, at the time she was first admitted, and again on the night of her discharge.[50] However, the Discharge Against Medical Advice form does not indicate that R1 was advised of these risks on that night.[51] Nor do the nursing notes reflect such a conversation before R1 left that night.[52] Facility staff called for a taxi to come pick up R1. R1 waited calmly for the taxi and left in it at 2:45 a.m., telling staff she was going to her sister's for the remainder of the night.[53]

Facility staff immediately notified R1's physician that R1 had been voluntarily discharged from the Facility.[54] Later that morning, Ms. Hilgert notified Adult Protection

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[45] The Administrative Law Judge notes that the investigator did not say what he relied on in concluding that R1 said she wanted to stay at the Facility. There is nothing in R1's records or in the summary of the staff interviews that reflects this statement. However, the Facility did not dispute the investigator's testimony regarding R1's statement.
[46] Test. of K. Pankratz; Department Summary at 4; Facility Summary at 3.
[47] Ex. 14.
[48] Ex. 14.
[49] Facility Summary at 3.
[50] Test. of M. Yates
[51] Test. of K. Pankratz; Ex. 14.
[52] *See* Ex.1 at 12; Ex. 9 at 2.
[53] Department Summary at 4.
[54] Test. of K. Pankratz.

that R1 had left the Facility.[55] Adult Protection declined to investigate the matter.[56] Ms. Hilgert believes that R1 made a decision that she wished to leave the Facility.[57]

During the day on January 21, 2015, the Facility's Interdisciplinary Team met to review R1's discharge. The team members confirmed that R1 was aware of her LOA Agreement and of the Facility's policies and procedures involving bed holds and voluntary discharges, including repeated discussions Facility staff had with R1 about these issues.[58] On January 21 or 22, 2015, R1 returned to the Facility with her daughter and picked up her belongings.[59]

Department's Argument

The Department contends that R1's discharge was involuntary because, even though R1 left the Facility without signing out as required and returned 45 minutes later than required, she did return.[60] The Department also relies on the following to support its conclusion that R1's discharge was involuntary:

- R1 stated she did not wish to leave when she returned.
- R1's discharge was initiated by Facility staff.
- R1's was required to leave the Facility at 2:45 a.m.
- R1 was required to leave the Facility alone in a taxi.
- R1 had to leave without her medications and most of her belongings.
- When R1 was asked to sign the form acknowledging that she was leaving at her own insistence against medical advice, R1 refused to do so.

Based on these indicia of involuntariness, the Department concludes that R1's discharge was not voluntary. Therefore, the Department argues, the notice requirements of 42 C.F.R. § 483.12(a)(4) applied and the F-203 tag was proper.

In addition, the Department argues that, to the extent the Facility's Leave of Absence policy requires a resident to abandon her bed at the Facility after an absence of less than 23 hours that constitutes a violation of the State plan requirements and the federal regulations. The basis for this argument is that 42 C.F.R. § 482.12(b)(1) (2014) requires written information to be provided to the resident, specifying the "duration of the bed-hold policy under the State plan . . . during which the resident is permitted to return and resume residence in the nursing facility. . . ." The Department maintains that, because the State plan says that a leave does not begin until a resident has been absent for 23

[55] Ex. 15; Test. of D. Hilgert.
[56] Ex. 15.
[57] Test. of D. Hilgert.
[58] Facility Summary at 3; Test. of K. Pankratz; Ex. 1 at 12.
[59] *Compare* Ex. 1 at 12 and Ex. 9 at 3. The two sets of notes reflect two different dates on which R1 returned for her belongings.
[60] Although R1 was not discharged until 2:45 a.m., she actually returned to the facility at 12:45 a.m., 45 minutes after the required return time.

hours, an absence of anything less than 23 hours cannot jeopardize the resident's entitlement to her bed, or invoke a bed-hold requirement.[61]

Facility's Argument

The Facility agrees that 42 C.F.R. § 483.12(a) (2014) requires proper and timely notice to a resident before a resident may be involuntarily transferred or discharged. The Facility states it has appropriate policies and forms for involuntarily discharging or transferring a resident. In addition, the Facility maintains its staff are appropriately trained in those procedures, and implementing them, including educating the residents of the Facility about those policies and procedures when the residents are admitted and during the residents' stays. The Facility also asserts that it has appropriate policies and procedures, including proper notice forms, for voluntary discharge situations.[62] The Facility states its goal is to insure that people taking LOAs leave the Facility in a safe way, with appropriate supports and medications. Furthermore, when the Facility follows its voluntary discharge against medical advice (AMA) policy with a fully cognitive resident who chooses to ignore the LOA rules, the Facility contends it is respecting the dignity and choice of that fully cognitive resident.[63]

The Facility maintains that it did not involuntarily discharge R1 and that the Department has misapplied the standards of an involuntary resident discharge to a voluntary discharge situation. The Facility states that R1 was well-educated about the policies and procedures concerning voluntary discharge and that a voluntary discharge is what occurred in her case.[64]

The Facility presented convincing testimony that its LOA policies are neither new nor unique in the nursing-home industry.[65] The Facility cites the State plan language, "[w]hen a ***resident initiates or decides*** to leave the facility (not for hospital or therapeutic leave), the discharge or transfer is voluntary"[66] arguing that this is a straightforward case of a voluntary decision to leave the Facility. The Facility contends that R1, a competent adult, decided to leave the Facility without signing out and did not return by midnight. The Facility maintains R1 was fully aware of the consequences of her actions, and her decision should be respected.[67] Moreover, the Facility argues, the Department's position means there is no such thing as a voluntary discharge. From a functional standpoint, the Facility asserts that the Department's view logically leads to the conclusion that "the only way a facility can *try* to remain compliant with F203 is to issue each and every resident a written notice of involuntary discharge or transfer each and every day that resident is at

[61] Department Summary at 5; Test. of Michelle Ness.
[62] Facility Summary at 4.
[63] Test. of Deb Rose.
[64] Facility Sumary at 4.
[65] Test. of K. Pankratz, M. Yates, Deb Rose.
[66] Ex. E at E-9 (emphasis in original).
[67] Test. of D. Rose.

the facility to ensure at least 30 days advance notice is given before that resident leaves the facility."[68]

Analysis

There is no question that R1 signed the Admissions Agreement, the LOA Agreement, and the Responsibility Agreement, and received a copy of the Bed-Hold Policy. There is also no question R1 had all of these documents explained to her by Facility staff. In addition, the State plan explicitly says that a resident who "***initiates or decides*** to leave"[69] a facility is voluntarily discharging herself. The question in this case, however, is whether R1 initiated her discharge or decided to leave and, if so, whether that constitutes a voluntary discharge under the applicable federal rules and the State plan.

The plain language of 42 C.F.R. § 483.12 (2014), on which the F-203 tag is based, applies to a discharge initiated by a facility. The opening sentence of the regulation reads "Before a facility transfers or discharges a resident, the facility must . . . ." The subject of this sentence is "a facility." A facility is acting to transfer or discharge "a resident." The resident is the object of the sentence. The resident is not the one taking an action in the sentence. This regulation creates a 30-day advance notice requirement designed to protect residents from being discharged involuntarily, inappropriately, or unsafely. In addition to the actual notice, the applicable regulations include, among other things, appeal rights, and a requirement that the resident be provided with contact information for the State long term care ombudsman.[70]

The Facility asks the Department and the Administrative Law Judge to presume a voluntary discharge on R1's part based on her prior agreements, regardless of subsequent behavior on her part indicating that she did not wish to be discharged. If the Facility prevails, none of the protections connected with the F203 tag will apply. The Administrative Law Judge can only give the agreements a limited amount of weight, because a resident is not in a position, at the time she enters the Facility, to refuse to agree to the terms of the various agreements that Facility management presents to her. While R1 was fully cognitive and able to make her own decisions, she was also, by definition, vulnerable.[71] She and the Facility were not equal bargaining partners. If R1 objected to the terms of the Facility's agreements and policies, yet was in need of the care the Facility could provide, she had few options. R1's presumptive voluntary discharge must be examined carefully given both the circumstances that created it initially and the circumstances that triggered its implementation.

This is especially so because R1 returned well within the 23-hour period allowed before the need for a bed-hold even arises under the State plan and federal law; and unlike the other examples of residents who left and were presumed voluntary discharges,

[68] Facility Summary at 5.
[69] Ex. E at E-9 (emphasis in original).
[70] 42 C.F.R. § 483.12(a)(4), (6).
[71] *See* Minn. Stat. § 626.5572, subd. 21 (2014) (defining "vulnerable adult").

R1 returned, expressing a desire to stay at the Facility; and R1 refused to sign the AMA Discharge form.

Under the State plan and federal law, the Facility had an obligation to hold R1's bed for 23 hours before the Bed-Hold Policy could become effective. It is likely that, when R1 returned to the Facility at 12:45 a.m., a mere 45 minutes late, her bed was still standing empty in her room. There was no evidence that she was intoxicated, aggressive, or in a condition that would have made it inappropriate for her to be permitted to return to the Facility. While she was in violation of two Facility policies, there is no evidence in the record concerning why R1 violated the policies. She could have simply forgotten to sign out. She had faithfully signed out every other time that she went out on an LOA. There might have been a family emergency. R1 did not take her belongings with her when she left on January 20, despite the fact that her daughter was with her and presumably could have helped her. Apparently R1 had belongings that she wanted because she and her daughter later came back and retrieved them. Thus, Ms. Hilgert's belief that R1 decided that she wished to leave the Facility is puzzling.

By 12:45 a.m. on January 21, 2015, while her bed was still legally available to her, R1 returned to the Facility, and expressed a desire to stay. When presented with the form which required her to state that she was leaving at her own insistence, R1 refused to sign it. At that time, R1 was clearly not a voluntary discharge, notwithstanding the Facility's forms and policies.

The Facility argued that R1's discharge was voluntary under the State plan's definition of a voluntary discharge. But when R1 left the Facility on January 21, 2015 at 2:45 a.m., she had not *initiated* her own departure, nor had she *decided* to leave the Facility, because there were intervening events between her initial departure during the afternoon of January 20, 2015 and the departure in the middle of the night. Whatever her initial thinking was when she left the afternoon before, it appears that less than twelve hours later, R1 decided not to leave the Facility. What occurred thereafter was no longer voluntary. It was initiated by the Facility. Ms. Rose's statement that the Facility was simply respecting the dignity and choice of a fully cognitive resident rings hollow when placed in the context of R1 being sent away from the Facility in a taxi at 2:45 a.m. without her belongings or her medications. Such treatment is neither dignified nor safe, especially given that R1 did not want to go.

The Facility argues that this reasoning could lead to the irrational situation where there could never be a voluntary discharge. Nothing in this result prevents the Facility from having a LOA policy or a voluntary discharge procedure in place that is consistent with federal and state law. In many of the hypothetical situations posited in the Facility's Summary (e.g., a cognitive resident decides she wants to leave the facility, a resident's guardian chooses to move the resident to another facility, a resident goes on an LOA and simply does not return), it is clear that the discharge would be voluntary and no notice would be required under F-203.

The Facility should not be permitted to label R1's discharge as voluntary based solely on her earlier acknowledgement of the Facility's policies. She was cognitive and

competent to make her own decisions at the time of the actual discharge and her conduct at that time was affirmatively resistant to the discharge. In addition, the Facility's involuntary discharge of R1 within less than 23 hours of her leaving the Facility based on her failure to make bed hold arrangements violated the requirements of the State plan and federal law. The deficiency should be affirmed as written at a scope and severity of D.

L. S.